

EXHIBIT J

JAMES F. MENAPACE, M.D.

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Ambler, PA 19002

Telephone: (215) 653-0270

May 27, 2003

David F. White, Esquire
Kelly, McLaughlin, Foster, Bracaglia,
Daly, Trabucco & White, LLP
620 West Germantown Pike
Suite 350
Plymouth Meeting, PA 19462-1056

RE: Jackson vs Wackenhut, et al.

Dear Mr. White:

As you requested, I have reviewed the following records concerning the medical and psychiatric treatment of Mr. Arthur Jackson: records from Crozer Chester Medical Center, admission date 5/28/00, discharge date 6/3/00; records from Crozer Chester Medical Center, admission date 6/4/00, discharge date 6/7/00; medical records from Lee D. Silverman, M.D., multiple records concerning Dr. Silverman's care of Mr. Jackson for approximately two years; medical records from Celsus Ebba, M.D., Mr. Jackson's family physician, these are records of office visits and laboratory records of Arthur Jackson over several years; deposition transcription of Arthur Jackson, Part I, February 20, 2003, and Part II, March 17, 2003. Also reviewed was a report from Rehab Nurse Consultants dated February 20, 2003, prepared by Betsy Bates, B.S. Also sent to me were reports concerning Mr. Jackson's prescriptions received from CVS Pharmacy as well as from The Medicine Shoppe, another pharmacy.

Mr. Arthur Jackson was incarcerated at Delaware County Prison on 5/26/00, apparently around 5:00 p.m. Friday evening and preparing for release on Sunday, 5/28/00, at 6:00 p.m. in the evening when this unfortunate individual either fell down or had a seizure resulting in a head injury.

My review of the records from Crozer Chester Medical Center are somewhat confusing in that the trauma attending admission record states that the patient was a forty-seven year old African American male prisoner, fell down, seizure for three minutes, questionable loss of consciousness, now complaining of headache. This sheet is dated 5/28/00 at 7:15 p.m., and the mechanism of injury is called a fall. A second sheet, a history sheet from Crozer Chester Medical Center dated 5/28/00, states that Mr. Jackson fell from a standing position and hit his head with a positive loss of consciousness and a positive seizure, now with bleeding from his head.

Review of the medical records reveal that Mr. Jackson did suffer a significant head injury, the mechanism, whether this was fall or seizure is unclear. His diagnosis at the time of admission to Crozer Chester Medical Center is that of a right subdural hematoma, right frontal lobe contusion and possible basilar skull fracture. Upon his arrival, the patient is treated as a trauma patient. He

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had complete evaluations concerning his medical condition. He undergoes a CAT scan of the head and the abdomen, has x-rays of his cervical spine as well as a CAT scan of his cervical spine, has blood work as well as urine samples sent to the lab. His urine was sent for a urine drug screen at that time. Of note is that Mr. Jackson also had an alcohol level sent which was reported as zero. The urine drug screen was negative for amphetamines, barbituates, benzodiazepams, THC, cocaine metabolites, opiates and PCP. Insulin for the patient's blood glucose was 461, as stated before, on admission to the Emergency Room. Of interest was that Mr. Jackson was noted to be awake and alert and oriented. He responded appropriately, followed commands and was found, according to the medical records, to have no neurologic deficits at that time. His Glasgow Coma Scale was 15, which is essentially normal.

The patient was able to give an adequate medical history according to the in-patient records of that day of 5/28/00. It is recorded that he is able to give a medical history of having diabetes, depression and able to tell the staff his medications. Also of note is that the patient's serum sodium at the time of admission to Crozer Chester Medical center was recorded as 126, being somewhat low with the normal value being 135 to 146 MMOL/L. Mr. Jackson is admitted to the Intensive Care Unit where he undergoes conservative therapy in the sense that no surgical interventions took place nor did he require any specialized treatment besides observation and the addition of Dilantin to prevent seizures. The patient was seen by various consultants while in the Intensive Care Unit and in the hospital and is subsequently discharged to the rehabilitation on 6/3/00.

I also reviewed records from Dr. Silverman, Mr. Jackson's psychiatrist. There are multiple notes from Mercy Psychiatric Associates dating from 1999 until most recently, April of 2003. Dr. Silverman's diagnosis is, on several of the sheets, and these are at the top of his progress notes, and they are highlighted as diagnosis/target symptoms, several diagnoses are stated that of depression, anxiety, ethanol abuse and insomnia. It appears from the records that Dr. Silverman has followed Mr. Jackson for several years and prescribed medications such Klonopin, Effexor and Trazadone.

There is no mention of seizure disorder in the records that I reviewed from Dr. Silverman. Also reviewed was a three page letter apparently dictated by Dr. Silverman addressed to Mr. John L. Rollins dated January 1, 2003, in which Dr. Silverman talks about his relationship with Mr. Jackson and his treatment of Mr. Jackson. In his letter to Mr. Rollins, Dr. Silverman answers a question, and I will quote the question, "Do you agree that the injuries (subdural hematoma with subarachnoid hemorrhage) for which you have been treating him since May 29, 2000, were caused by the deprivation of physician prescribed medications (i.e., Insulin, Klonopin, etc.) while Mr. Jackson was incarcerated in Delaware County Prison?" Dr. Silverman answers, and I quote, "It is my understanding that Mr. Jackson was not given his psychiatric medications or his Insulin. Given that Mr. Jackson was not intoxicated at the time nor was he drinking on a regular basis, it is my belief that the seizure was more than likely due to abrupt cessation of the Klonopin and lack of Insulin. I do remember faxing Mr. Jackson's psychiatric medication records to the

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nurse or physician in the prison so they would have had an updated record of the medications that I was prescribing for him."

After review of the medical records concerning Mr. Jackson's past medical history and psychiatric history, I disagree with Dr. Silverman that the seizure was more than likely due to an abrupt cessation of Klonopin and the lack of Insulin. First and foremost is that the patient's blood glucose at the time of admission to Crozer Chester Medical Center was 461. This is an elevated glucose. There is nothing in the medical literature to support seizures or falls because of an elevated glucose in the 400's. Had the patient taken too much Insulin and his glucose was low, less than 70, then the possibility of a seizure would be considered. To my medical knowledge after twenty years of emergency medicine practice, I have never encountered nor read of a case of a patient having a seizure due to a lack of Insulin and a blood glucose of 461. I also disagree with Dr. Silverman's conclusion that the abrupt withdrawal of Klonopin was the reason for the patient's head trauma. My reasoning for disagreeing with him is first the urine drug screen performed at Crozer Chester Medical Center on Mr. Jackson's urine when he arrived in the Emergency Room. The records reveal that the urine drug screen was negative and there were no detectable benzodiazapam metabolites in Mr. Jackson's urine. The pharmacology of benzodiazapam metabolism is such that if Mr. Jackson had been taking his Klonopin, as he states, daily, in the doses provided which were therapeutic, three times a day, then there would have been detection of benzodiazapams in his urine. I refer you to an enclosure called, Drug Detection Time In Urine Following Last Dose. This is from Quest Diagnostics out of Cambridge, Massachusetts, Quest Diagnostics being one of the largest national reference laboratories.

The sheet reflects that after acute use, benzodiazapams would be detected in the urine for up to three days and chronic use would be up to four to six weeks. It is my understanding that Dr. Silverman prescribed Klonopin for Mr. Jackson on a daily basis. Had Mr. Jackson been taking his Klonopin as prescribed, it is more likely that he would have had benzodiazapams detected in his urine. This leads me to conclude that it had been at least several days since Mr. Jackson had not taken his Klonopin and at least three days in the acute phase, yet he was treated on a regular basis and I would expect that his benzodiazepams would be detectable in his urine for weeks afterwards because of the pharmokinetics of benzodiazepam metabolism if used in a therapeutic dose as prescribed for Mr. Jackson.

Simply put, it appears to me that, after review of the medical records, Mr. Jackson had not taken Klonopin in quite a while since his urine drug screen was negative for benzodiazapams, there was no detectable threshold level for benzodiazapams in his urine and again, if you read, the Quest Diagnostics reference sheet concerning urine benzodiazapams, that should have been detectable. I also refer to you to Clinical Management of Poisoning and Drug Overdose, Second Edition, by Lester M. Haddad, M.D., F.A.C.E.P. and James F. Winchester, M.D., F.R.C.E.P., W.B. Saunders Co., page 58, Laboratory Diagnosis and Drug Testing. There is a chart which is labeled "Table 36, with the heading "Approximate Duration of Detectability of Selected Drugs in

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the Urine." Under the drugs is listed benzodiazepam and there is a three day approximate duration of detectability.

Again, I base my argument and my conclusion on these reference texts and references from diagnostic labs that if Mr. Jackson had been taking his Klonopin the week prior to his admission to Delaware County Prison, his urine drug screen should have been positive for benzodiazapams. My opinions are made with a reasonable degree of medical certainty.

The third argument against this being a result of the patient not receiving his Klonopin during the two days of incarceration at Delaware County Prison, is that Mr. Jackson did not manifest any of the symptoms of benzodiazepam withdrawal. I am assuming that Dr. Silverman attributes Mr. Jackson's head injury to a questionable seizure or fall as the result of abrupt cessation and I am assuming he means withdrawal of benzodiazapams. Unfortunately, if you read the literature, the syndrome of benzodiazepam withdrawal is very similar to that of alcohol withdrawal. Patients who withdraw from benzodiazapams can show increased anxiety, apprehension, agitation, tremors, headaches and less common symptoms are that of nausea, vomiting and palpitations. Seizures have been reported, and may occur up to two weeks following cessation or stoppage of benzodiazapams. Again, I base my argument that this was not related to Mr. Jackson's not receiving his Klonopin for two days while in Delaware County Prison because of his lack of symptoms of benzodiazepam withdrawal when he was admitted to Crozer Chester Medical Center. There is no mention of benzodiazepam withdrawal during his hospitalization as a result of his fall. I also support my contention that Mr. Jackson had stopped his Klonopin well before his incarceration of May 26, 2000, with reference to the letter to John Rollins, Esquire, from Dr. Gzesh. I quote the second paragraph in Dr. Gzesh's letter to Mr. Rollins, "He currently suffers from the neurologic sequelae of a severe head injury. I believe the injury, a subdural hematoma, was related to the deprivation of Clonazepam which he had been receiving on a chronic bases, which led to a seizure and subsequent head injury." Again, it is my medical opinion with a reasonable degree of medical certainty that Mr. Jackson was not taking his Klonopin as directed. Had he been taking it daily on a chronic basis for his depression and anxiety, then his urine drug screen would have been positive for benzodiazapams at the time of admission to Crozer Chester Medical Center on May 28, 2000, when he suffered his fall or seizure resulting in his head injury.

Review of Dr. Silverman's progress notes concerning the treatment of Mr. Jackson also reveal that Mr. Jackson was abusing alcohol well before his accident in which he fell and suffered a head injury on May 28, 2000. Another possible cause for Mr. Jackson's fall or seizure could have been acute alcohol withdrawal. Mr. Jackson was in the Delaware County Prison from May 26, 2000 to May 28, 2000, and I must assume that he was not allowed to drink alcohol during that period seeing that he was incarcerated for DUI at that time. It is conceivable that Mr. Jackson acutely withdrew and the resultant fall or seizure was again the result of alcohol withdrawal and subsequently leading to Mr. Jackson's injuries.

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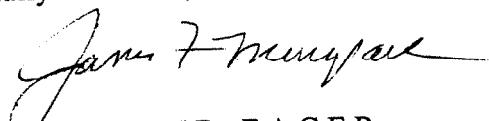
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It is my further opinion that had Mr. Jackson been taking Klonopin the week prior to his weekend incarceration beginning May 26, 2000, his urine drug screen should have been positive for benzodiazapams and further, if he had been taking Klonopin on a regular, therapeutic basis, benzodiazapams would be detectable in his urine for weeks. I must therefore conclude that Mr. Jackson had not taken Klonopin in quite a while as his urine drug screen was negative for benzodiazapams. Additionally, it is conceivable that Mr. Jackson's fall or seizure was the result of alcohol withdrawal.

All of the above opinion are made with a reasonable degree of medical certainty.

If I can be of any further assistance in this matter, do not hesitate to contact me.

Respectfully submitted,



James F. Menapace, M.D., F.A.C.E.P.

JFM/me

DRUG DETECTION TIME IN URINE FOLLOWING LAST DOSE

The duration of excretion of detectable amounts of drug in the urine following last intake is highly variable. A general rule of thumb is five plasma half-lives. This is simply a rough estimate given the following variables: route of administration, amount of drug taken, frequency of use, individual metabolism, urinary pH, and drug storage within body.

The usual drug screen includes the tests below

<u>DRUG</u>	<u>DETECTION TIME IN URINE</u>	
	<u>ACUTE USE</u>	<u>CHRONIC USE</u>
Amphetamines	one day	several weeks
Barbiturates	short acting (e.g. Seco): one day long acting (e.g. Pheno): 2-3 weeks	
Benzodiazepines	3 days	4-6 weeks
Cocaine Metabolites	2-3 days	several days
Codeine/Morphine	2-4 days	several days
Methadone	2-3 days	1-2 weeks
PCP	up to 1 week	1-2 weeks
Propoxyphene	1-2 days	several days
Marijuana	single smoke: moderate use: heavy use passive inhalation:	up to 4 days up to 10 days up to 4-6 weeks negative
Nicotine	moderate use: 1-2 days	

SOURCE: Quest Diagnostics, Cambridge, Massachusetts

Clinical Management of

POISONING AND DRUG OVERDOSE

Second Edition

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Beaufort Memorial Hospital
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Richland Memorial Hospital/USC School of Medicine
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W.B. SAUNDERS COMPANY

Harcourt Brace Jovanovich, Inc.
Philadelphia ■ London ■ Montreal ■ Toronto ■ Sydney ■ Tokyo

58 ■ LABORATORY DIAGNOSIS AND DRUG TESTING

Table 3-6. APPROXIMATE DURATION OF DETECTABILITY OF SELECTED DRUGS IN URINE

DRUG	APPROXIMATE DURATION OF DETECTABILITY*	LIMITS OF SENSITIVITY OF ANALYTIC TECHNIQUES ($\mu\text{mol/L}$)
amphetamine	48 hr	0.5 $\mu\text{g/ml}$
methamphetamine	48 hr	0.5 $\mu\text{g/ml}$
barbiturates		
<i>Short-acting:</i>	24 hr	
hexobarbital		1.0 $\mu\text{g/ml}$
pentobarbital		0.5 $\mu\text{g/ml}$
secobarbital		0.5 $\mu\text{g/ml}$
thiamylal		1.0 $\mu\text{g/ml}$
<i>Intermediate-acting:</i>	48-72 hr	
amobarbital		1.0 $\mu\text{g/ml}$
aprobarbital		1.5 $\mu\text{g/ml}$
butabarbital		0.5 $\mu\text{g/ml}$
butalbital		1.5 $\mu\text{g/ml}$
<i>Long-acting:</i>	≥ 7 days	
barbital		5.0 $\mu\text{g/ml}$
phenobarbital		1.0 $\mu\text{g/ml}$
benzodiazepines	3 days†	1.0 $\mu\text{g/ml}$
cocaine metabolites	2-3 days	
benzoylegonine		0.5 $\mu\text{g/ml}$
ecgonine methyl ester		1.0 $\mu\text{g/ml}$
methadone	≈ 3 days	0.5 $\mu\text{g/ml}$
1,5-dimethyl-3,3-diphenyl-2-ethylidene pyrrolidine (metabolite of methadone)	≈ 3 days	
codeine	48 hr	0.5 $\mu\text{g/ml}$
morphine		0.5 $\mu\text{g/ml}$
propoxyphene	6-48 hr	1.0 $\mu\text{g/ml}$
norpropoxyphene		0.5 $\mu\text{g/ml}$
cannabinoids	3 days,‡ 5 days§	
(11-nor-9-tetra-hydrocannabinol-9-carboxylic acid)	10 days	20 ng/ml
methaqualone	21-27 days¶	1.0 $\mu\text{g/ml}$
phencyclidine	≥ 7 days	
	= 8 days	0.5 $\mu\text{g/ml}$

*Interpretation of the duration of detectability must take into account many variables, such as drug metabolism and half-life; subject's physical condition, fluid balance, and state of hydration; and route and frequency of ingestion. These are general guidelines only.

†Using therapeutic dosages.

‡Single use.

§Moderate smoker (4 times per week).

||Heavy smoker (smoking daily).

¶Chronic heavy smoker.

(From Report of Council on Scientific Affairs: Scientific issues in drug testing. JAMA 257:3110-3114, 1987. Copyright 1987, American Medical Association.)

best approach would be the multilaboratory analyses of an authentic plasma or urine sample, with comparison to duplicate laboratory GC-MS analyses as the reference. Such materials are now becoming available as a result of proficiency testing programs that produce survey-validated samples. The Forensic Urine Drug Testing (FUDT) program is jointly administered by the American Association of Clinical Chemistry (AACC) and the College of American Pathologists. It provides urine specimens containing the most commonly abused drugs and metabolites, as does

Pathologists also sponsors toxicology survey programs with both serum and urine specimens. In addition, the military and various states provide such programs.

Workplace Drug Testing. In recent years, workplace (employee) drug testing of urine and other nonclinical substance-abuse testing (athletic programs, the military, correctional facilities, etc.) have become widespread. In order not to jeopardize the livelihood and due process rights of the individuals being tested, laboratories must produce results that are scientifically and forensically defensible.

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SOCIAL SECURITY #: 181-40-2948

DATE OF BIRTH: August 1, 1949

PLACE OF BIRTH: Wilkes-Barre, Pennsylvania

OFFICE ADDRESS:
Warminster Hospital
225 Newtown Road
Warminster, PA 18974

EDUCATION:

- | | |
|-----------|---|
| 1976-1980 | Doctor of Medicine
Temple University, School of Medicine
Philadelphia, Pennsylvania |
| 1975 | Temple University, Graduate Studies
Philadelphia, Pennsylvania |
| 1969-1972 | Bachelor of Science
Kings College
Wilkes-Barre, Pennsylvania |

POST GRADUATE TRAINING AND FELLOWSHIP APPOINTMENTS:

- | | |
|-----------|--|
| 1980-1981 | Internal Medicine Internship
Temple University Hospital
Philadelphia, Pennsylvania |
| 1981-1983 | Internal Medicine Residency
Temple University Hospital
Philadelphia, Pennsylvania |

SPECIALTY CERTIFICATIONS:

- | | |
|------|---|
| 1983 | American Board of Internal Medicine
Diplomate, American College of Physicians |
| 1988 | American Board of Emergency Medicine
Diplomate, American Board of Emergency Medicine |
| 1989 | Fellow, American College of Emergency Physicians |
| 1995 | Certified Medical Review Officer
Medical Review Officer Certification Council |
| 1998 | Re-certification Examination
American Board of Emergency Medicine
Diplomate, American Board of Emergency Medicine |

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CERTIFICATIONS:

1983, 83, 87, 93
1990

American Heart Association
Advanced Cardiac Life Support Provider
Advanced Cardiac Life Support Instructor

1985
1988

American College of Surgeons
Advanced Trauma Life Support Provider
Advanced Trauma Life Support Instructor

HOSPITAL APPOINTMENTS:

6/83-9/83

Attending Staff, Emergency Department
Burdette Tomlin Memorial Hospital
Cape May Courthouse, New Jersey

10/83-7/87

Attending Staff, Emergency Department
Sacred Heart Hospital
Norristown, Pennsylvania

7/87-Present

Attending Staff, Emergency Department
Warminster Hospital
Warminster, Pennsylvania

ADMINISTRATIVE APPOINTMENTS:

1988-1991

Associate Director, Department of Emergency Medicine
Warminster Hospital
Warminster, Pennsylvania

1991-Present

Chairman, Department of Emergency Medicine
Warminster Hospital
Warminster, Pennsylvania

1994-Present

Director, Occupational Health
Warminster Hospital
Warminster, Pennsylvania

LICENSES:

Pennsylvania

PROFESSIONAL ASSOCIATIONS:

American College of Emergency Physicians
Board of Directors, Bucks County Emergency Health Council

HOSPITAL SERVICE:

1987-1989

Chairman, Disaster Committee
Warminster Hospital
Warminster, Pennsylvania

1988-1991

Associate Director, Emergency Services
Warminster Hospital
Warminster, Pennsylvania

James F. Menapace, MD, FACEP

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HOSPITAL SERVICE:

1990-Present	Physician Advisor Bucks County Emergency Health Council Bucks County, Pennsylvania
1991-Present	Director, Department of Emergency Medicine Warminster Hospital Warminster, Pennsylvania
	Voting Member, Medical Executive Committee Warminster Hospital Warminster, Pennsylvania
1992-1993	Member, Quality Council Warminster Hospital Warminster, Pennsylvania
1993-1995	Chairman, Quality Care Committee Warminster Hospital Warminster, Pennsylvania
	Member, Hospital Operations Warminster Hospital Warminster, Pennsylvania
1996-1999	Physician Advisor Enterprise Fire Company Hatboro, Pennsylvania
1997-Present	Bucks County Regional Medical Director Bucks County Emergency Health Council, Inc. Doylestown, Pennsylvania
1996-1998	Medical Director, Telephone Answering Nurse Triage Service Allegheny Health, Education and Research Foundation
1997-1998	Member, Ambulatory Quality Improvement Committee Allegheny Health, Education and Research Foundation
1998-Present	Vice-President, Medical Staff Warminster Hospital

EXHIBIT K

1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE EASTERN DISTRICT OF PENNSYLVANIA
3 CIVIL DIVISION

4 - - -
5 ARTHUR JACKSON, III :
6 :
7 vs. :
8 DELAWARE COUNTY, et al : NO. 02-CV-3230
9 - - -
10

11 Deposition of VICTORIA GESSNER,
12 M.D., taken on behalf of the Plaintiff, at
13 the George W. Hill Correctional Facility,
14 Cheyney Road, Thornton, Pennsylvania, on
15 Wednesday, December 17, 2003, commencing
16 on or about 2:15 p.m., before Renee
17 Fazio-Callahan, Court Reporter and Notary
18 Public.

19 - - -
20 FARRELL COURT REPORTING
21 3223 Polk Road
22 Norristown, Pennsylvania 19403
23 (610) 584-8787
24 - - -

1 in the section. The second page has three

2 --

3 A. It looks like this one.

4 MR. HERBERT: What's the
5 date on that?

6 BY MR. HOWARD:

7 Q. This appears to be the same. You
8 had indicated you prescribed Librium for
9 Mr. Jackson during his incarceration in
10 2000?

11 A. I believe I saw a prescription
12 written for Librium times one dose on 2/26
13 indicating that -- go ahead. I'm sorry.

14 Q. What would that indicate to you?

15 A. It would indicate that he needed
16 to be covered with Benzodiazepine.

17 Q. I apologize, in laymen's terms,
18 what are you --

19 A. Certain kind of medication.

20 Q. Why did he need to receive that,
21 a certain type of medication?

22 A. There's not an entry from the
23 nurse. I could quickly envision several
24 scenarios: One, that he didn't bring his

1 normal prescribed medications. Two, that
2 he was in danger of withdrawing from
3 alcohol and/or another medication, and
4 that would cover him for any adverse
5 sequelae.

6 Q. Now, you were referencing Page
7 32 when we were discussing what medication
8 you prescribed Librium for him; is that
9 correct? That's Page 32 of the
10 Exhibit-12.

11 A. 32, yes. First of all, if he had
12 -- well, I'll wait for your question.
13 I'm sorry.

14 Q. The question was: You were
15 referring to Page 32; is that right?

16 A. 32 and 31.

17 Q. Okay. And 32 references -- the
18 reference to Librium is for what you
19 prescribed on February 26th, 2000; is that
20 right?

21 A. Yes.

22 Q. Now, I think a little earlier we
23 had discussed Page 16 of Exhibit-12. That
24 was the receiving screen and health

1 see just above the handwritten numbers it
2 says Page one of five. It goes to Page
3 five of five.

4 Have you seen this
5 document before?

6 A. No.

7 Q. Were you familiar with the
8 weekender program policy that was in place
9 in 2000?

10 A. To some extent.

11 Q. What do you recall regarding
12 that policy?

13 A. I recall inmates were to bring
14 their own medications; however, medical
15 judgment would supercede that. It doesn't
16 mean you'd automatically be given what you
17 brought, not if it would be at the time
18 mental.

19 I recall insulin was --
20 needles were not taken to the unit. They
21 were brought to the Medical Department.

22 Q. Now, when you said you recall
23 the inmates were supposed to bring
24 medications to the prison, can you turn to

1 but I thought I heard you say thank God.

2 Do you remember saying that?

3 A. Yes.

4 Q. Why did you say that?

5 A. Mr. Jackson's excessive dose of
6 Klonopin would actually be detrimental in
7 someone who admits to drinking, taking
8 that much Klonopin would have a variable
9 and unpredictable effect on him to include
10 hypotension and perhaps death.

11 Q. Would that cause you to be
12 reluctant to administer Klonopin to Mr.
13 Jackson?

14 A. I obviously was very reluctant
15 to administer or prescribe Klonopin to Mr.
16 Jackson. They're exceedingly high dosages
17 and in someone who drinks alcohol, as I
18 said, it would be a relative if not an
19 absolute contraindication.

20 Q. Doctor, I notice you brought
21 your file. Do you have the Crozer Keystone
22 records in there? I have a partial copy
23 of those records, but I do not believe I
24 have all of the Crozer Chester records.

1 diabetic. It looks like there was a
2 question as to whether or not he had a
3 seizure while he was waiting for the bus.
4 They documented his basic skull fracture
5 and agreed that no surgical intervention
6 was needed. And they just ordered the
7 appropriate labs for a neurologic workup
8 on 5/28. He was awake and alert.

9 BY MR. HERBERT:

10 Q. Do any of those records indicate
11 his sodium level?

12 A. They document here that he does
13 have a cerebral contusion and possibly a
14 baseline seizure disorder, but that it
15 appears that hyponatremia was determined
16 to be the cause of his seizure.

17 Q. What is hyponatremia?

18 A. A low sodium in the blood.
19 Essentially it's like diluting out your
20 blood. It appears that he admitted to
21 excessively drinking water. We refer to
22 it as hypogenic polydipsia.

23 Q. That is what the excessive
24 drinking of water?

1 A. Uh-huh. Pre-water without solids
2 in it. When your sodium gets below a
3 certain level, you have a seizure.

4 Q. In your experience as a doctor
5 here at this facility, is there any reason
6 why someone would be drinking that much
7 water that would cause hyponatremia?

8 MR. HOWARD: Objection;
9 calls for speculation. You can answer.

10 THE WITNESS: You asked
11 in my experience. In my experience here in
12 the prison I've had people do it
13 deliberately to knowingly cause seizures.
14 I've had people do it in an attempt to --
15 or people who just do it as like an
16 obsessive compulsive kind of manifestation
17 of OCD. I've had people do it in an
18 desperate attempt to dilute out any drugs
19 or alcohol they have in their system to
20 reduce the levels for a urine test.

21 BY MR. HERBERT:

22 Q. I do not have the documents in
23 front of me, but when I spoke to you the
24 other day when we met, we looked over a

1 document that indicated a blood test of
2 Mr. Jackson when he was taken to the
3 emergency room at Crozer Chester on May
4 28th, 2000.

5 There was
6 Benzodiazepine level that was indicated to
7 be zero. No trace at all. What does that
8 tell you, if anything?

9 MR. HOWARD: Objection.

10 MR. REIL: Note my
11 objection to a document that's not here.

12 BY MR. HERBERT:

13 Q. Do you recall us reviewing the
14 document?

15 A. Yes, I do.

16 Q. What does that indicate to you?

17 A. It indicated to me when I
18 reviewed that he had not had any
19 Benzodiazepine in his system with a long
20 half life or a significant amount of time.

21 Q. What do you consider a
22 significant amount of time?

23 A. It depends on the Benzo. In
24 order to not detect it, you have to have at

1 least completed five half lives. So if you
2 took something like Valium, which has a
3 long half life, say 24 hours, it would be
4 at least it would take a week to two weeks
5 for Valium. Something like Klonopin which
6 is an even longer half life, would be in
7 his system for weeks.

8 Q. What if Mr. Jackson had been
9 taking the Klonopin that was prescribed to
10 him by Dr. Silverman, which I believe was
11 five milligrams per day, if he had been
12 taking that as prescribed throughout the
13 week, would there have been traces in his
14 bloodstream when he was presented to
15 Crozer?

16 MR. HOWARD: Objection.
17 It calls for speculation. The witness has
18 not been qualified as an expert.

19 BY MR. HERBERT:

20 Q. You can answer.

21 A. In my experience, in my opinion,
22 if he was drinking like he said he was, he
23 probably would have never made it to the
24 hospital, because he probably would have

1 co-signature. Usually when I read
2 something of importance, I'll co-sign it
3 and it's an antiquated prescription. I
4 don't know where it came from.

5 MR. HOWARD: Thank you.

6 BY MR. HERBERT:

7 Q. Read the date on the
8 prescription.

9 A. 9/22/99 with no refills.

10 Q. Regarding the documents that we
11 reviewed, you reviewed, the Crozer Chester
12 records, you talked about lab results. You
13 talked about the sodium being in the 120s.
14 Do you recall what the Benzodiazepine
15 level was?

16 A. I didn't see any. I think it
17 was zero level.

18 Q. What does that indicate to you?

19 A. That at least five half lives
20 had transpired since his last
21 Benzodiazepine ingestion.

22 MR. HOWARD: Objection.

23 THE WITNESS: So this
24 was not a valid prescription at the time

1 of his incarceration.

2 BY MR. HERBERT:

3 Q. You're talking about the
4 document Mr. Howard placed in front of
5 you?

6 A. I'm concerned about where this
7 came from.

8 Q. I'm not sure. I've never seen
9 it.

10 BY MR. HOWARD:

11 Q. Last question, five half lives
12 is that a number of days?

13 A. No, it depends on the half life.
14 So, if you take a drug that's out of your
15 system or say the drug level you reach is
16 a steady state level and you -- it's the
17 length of time it takes for that blood
18 level to be cut in half. It depends on how
19 you metabolize it. If that's 24 hours,
20 normally after it's cut in half by five,
21 we can consider it to be out of your
22 system.

23 Q. Does the half life change
24 depending upon the patient's weight?

1 A. It depends on many, many things,
2 but there's -- that's why there's a range,
3 but certain drugs are known to have long
4 half lives, some are very short.

5 Q. Does it change if they have
6 other medical conditions?

7 A. Yes.

8 Q. Does it change if they're taking
9 other medications for those medical
10 conditions?

11 A. Yes, within a certain range.

12 MR. HOWARD: Thank you
13 very much, Doctor.

14 - - -

15 (Exhibits Gessner-two,
16 Gessner-three, Gessner-four and
17 Gessner-five were marked for
18 identification.)

19 - - -

20 (At 5:05 p.m.,
21 proceedings were concluded.)

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